

Sharsheret's National Book Club with Dr. Elisa Port, author

The Breast Advice

All You Need to Know about Breast Health, Screening, and Treatment

National Webinar Transcript

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Presented by:



SHARSHERET

The Jewish Breast & Ovarian Cancer Community

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Melissa Rosen:

Thank you so much for being with us tonight for what is sure to be a wonderful conversation. Tonight's webinar is part of Sharsheret's annual summit, and we're here together to continue to learn from all the information that the summit provides. This webinar, Sharsheret Book Club. We do the book club two to three times a year. Sharsheret's book club, The Breast Advice with Dr. Elisa Port is part of that annual summit, which brings together thousands of people, both virtually and in person across the country and beyond from September 18th of this year to October 23rd.

The Sharsheret Summit is a source of the latest information on breast cancer and ovarian cancer, and we encourage you to visit our summit website and check out our virtual toolkit. A link to the Summit website is in the chat box right now.

I want to take a moment to thank our Sharsheret Summit sponsors, the Cooperative Agreement 240061 of the Centers for Disease Control and Prevention, AstraZeneca, Eisai, GSK, Lilly, Pfizer, Smart State, and Weill Cornell Medicine, Department of Genetics and Personalized Cancer Prevention. Additionally, thank you to the many summit program partners that you saw on the opening slides. Their partnership has helped make our summit a success.

Today's webinar is being recorded and posted on Sharsheret's website alongside a transcript, but as always, participants' faces and names will not be in the recording. Still, if you'd like to remain private, you have the option to turn off your video and rename yourself, or you can call into the webinar. Instructions on how to do both of those things are in the chat box now.

Additionally, we now have closed captioning available. To display live captions this evening on the bottom bar, click "captions" and then "show captions." It's that simple. You may have noticed you were muted upon entering the Zoom. Please stay muted during this program. You can, however, feel free to type your questions and comments into the chat box throughout the evening.

We'll have plenty of time to address them during our Q&A. As we move into the webinar itself, I want to remind you that Sharsheret is a national not-for-profit cancer support and education organization and does not provide any medical advice or perform any medical procedures. The information provided by Sharsheret and tonight's speaker is not a substitute for medical advice or treatment for specific medical conditions. You should not use this information to diagnose or treat a health problem. As always, if you have a concern, seek the advice of a qualified healthcare provider.

Okay. I want to get into the main program tonight because it's really exciting. We are so honored to be joined this evening by Dr. Elisa Port. Dr. Port is Chief of Breast Surgery at the Mount Sinai Health System, which encompasses multiple state-of-the-art breast centers. She personally consults with thousands of patients and performs hundreds of operations each year.

Thank you for the comment. Dr. Port is the best.

Dr. Port is a trusted voice in the media and a sought after speaker. All the more reason we're lucky to have her with us tonight. She has been featured in the New York Times on NPR, CBS, Today, Mornings with Maria, and Picks 11. In fact, she just shared with us that on October 1st, the kickoff of Breast Cancer Awareness Month, she will be back on the Today Show on NBC. So keep an eye out for that.

She's also frequently invited to share her expertise on podcasts and radio programs, including SiriusXM's, Perri Peltz Show, and Lipstick on the Rim. In addition to her media presence, Dr. Port regularly speaks at public events and is invited to present at conferences and on panels across the country. She is the author of New Generation Breast Cancer Book and the recently published book entitled The Breast Advice: All You Need to Know About Breast Health, Screening and Treatment. She lives in Manhattan with her husband and two dogs and has two grown children.

Welcome, Dr. Port.

Dr. Elisa Port:

Thank you so much. What a beautiful introduction, and I couldn't be more honored to be here. I know I'm very busy and I have a lot of demands on my time, but Sharsheret is a cause that is near and dear to my heart and has been for many, many years. We share a lot of patients together. We give each other a lot of support for our patients. And as a Jewish woman, I could not be prouder to be involved with Sharsheret and to support your mission to educate and to support women and men in their battles with breast cancer and ovarian cancer and so forth.

I also want to say I might have to steal the Sharsheret background. I love the pink background with the Sharsheret logo. Me, it looks like I have the Freedom Tower coming out of the top of my head, so you'll just ignore that or I'll move to the side so it doesn't look like it's like a pointy thing coming out of the top of my head.

What I thought I'd do today is talk a little bit about, give you all kind of a taste of what's in the book and a couple of other things that I think are really important. I wanted to divide the short talk I'm going to give before answering questions into three parts.

The first, I'd really like to talk about risk factors for breast cancer because I think there are always opportunities to educate people. And right now at this moment in time, I feel like if one woman, one Jewish woman reads the book and finds out information about how to screen herself, her risk to get genetic testing, it will have been worth it. And so the goal is really to educate women and to have an impact and have a positive impact. So the first I really want to talk about is risk factors for breast cancer.

The second topic I want to talk about briefly is screening. I think right now there is so much information out there, but unfortunately there's so much misinformation out there and the playing field related to information related to breast cancer is very, very muddy and rife with misinformation. And so I'd love to get that straight. And understand that this is stuff that I echo in the book where I try to really create clear guidelines for women that are totally evidence-based, based on the three main screening tools that we use in breast cancer, which are mammograms, ultrasounds, and MRIs.

And then the last part of this, and we could take this into Q&A, is debunking some common myths related to breast cancer. I think that that's always really important to do, again, addressing the misinformation. So let me just start out by talking about risk factors. So everyone out there, there's everyone, especially now and social media's got something to sell. They've got something that tells you that this increases your risk of breast cancer, that decreases your risk of breast cancer. Buy my immune booster, buy my peptides, buy my this, buy my that, it'll make you healthier.

For breast cancer, that's the only real topic that I'm kind of authorized or really knowledgeable to speak on. There are really only a few lifestyle factors that can impact risk of breast cancer. The first is weight, maintaining a healthy body weight. I know we live in an age where healthy body weight and self-image and all those things are always open for discussion, and there absolutely is a large range of what's considered healthy body weight. But what I always say to people is as much as we want to accept people for who they are, until I have a daughter who's 25 years old and tell her she's perfect the way she is, and I have, and that's how I raised her, there are lines that are potentially crossed where the weight becomes a health issue, above which becomes a health issue.

And you can define that related in a lot of different ways. Often BMI is used to gauge that, often waist to hip ratio. So there are a bunch of different definitions for healthy body weight. What I would say is that healthy body weight is one of the most important things for both breast and other cancer risks, and also for other diseases like heart disease. Let's just keep in mind right now that the number one killer of

women in America is not breast cancer. It's not cancer at all. It's heart disease. So heart disease, diabetes, all those things are all tied into weight, as are many cancers such as breast, colon, and uterine. So the most important message you should take from this though is that there's no specific dietary element that either increases or decreases the risk of breast cancer. It's not red meat, it's not tofu, it's not soy, it's not blueberries, it's not broccoli. None of those things taken in any kind of quantity either increase or decrease your risk of breast cancer. It's all about the common denominator of maintaining a healthy body weight. I.

Really tell women, my patients, both those who are at high risk for breast cancer or those who've developed breast cancer themselves, the times when I think that it's really important to start looking at weight and controlling weight, because remember if you're diagnosed with breast cancer, being overweight also increases your risk of recurrence. So it increases your risk of getting it in the first place and increases your risk of recurrence. And what I always say is that as women, as we get older, if you are at an unhealthy body weight, there's a very high likelihood you will end up on some type of medication related to that.

So if you are overweight and you are on a cholesterol medication, if you are on a medication that would go away if the weight was lost, that's probably crossing a line into unhealthy. If you're on a blood pressure medication because your weight is higher than where it needs to be, that's the same thing. The same for borderline diabetic medications, heart medications, et cetera. So I always use breast cancer, my patient's diagnosis, kind of a teachable moment. Where after they're done with the treatment and the trauma and everything that they go through, if you can sit down with someone in a very gentle way, and we do have a full-time nutritionist at our center, and talk to them about what are the opportunities here to get healthier across the board?

You're on Crestor, you're on Metformin for your sugar, you're on blood pressure medication, you're on a heart medication. If you lost X weight, those medications would probably go away. And I think it's really, really a teachable moment, as I said. I do, I'm very, very supportive of the use of the GLPs. I think it's really, as a postmenopausal woman myself, I think it's almost impossible to lose weight without help now. You basically have to starve yourself and that's not healthy either. And so I'm really, really a big fan of giving women the tools that they need. Whether it's exercise, whether it's nutrition counseling, whether it's education, also the medications.

And a lot of women turn to me, it's really interesting and say, "Well, aren't you afraid of side effects?" And they say, "How long would I need to be on that?" And I turn around to them and I say, "How long do you think you're going to be on your Crestor for? How long are you going to be on your Metformin for? Did you ask those questions?" And the answer is no, you're going to be on it for life as long as your weight is a problem. And so I think it's kind of a light bulb moment for some women as they view these medications, and I like to use them as a tool for those who need them. So I'm a very big supporter of that.

Along the lines of weight and lifestyle, the second main risk factor for breast cancer and risk for recurrence involves alcohol intake. And this is very, very depressing for a lot of people to hear because for many women, a glass of wine, champagne at a celebration, a bar mitzvah, whatever, it's very celebratory, and I am all for that. I think the thing that was a very rude awakening is we used to say that alcohol in moderation, three to five drinks a week, really did not increase your risk at all. And newer data suggests sadly that even small amounts have some added risk compared to nothing. So nothing is the safest amount.

And that's kind of unnerving and kind of a bummer, quite honestly. For a lot of people, if you don't have an alcohol problem, having a drink here and there is a part of a celebration. It's a part of enjoyment. It's

a part of a nice meal. It could be part of a lot of different things in life. And I really think that to be so draconian and drastic is really challenging. I do think that there are pleasures in life that people should enjoy, and I hate the idea of guilt. So a woman feeling like... A woman said to me a few days ago, she goes, "Is it okay for me to have a glass of red wine the night before my surgery? I'm so nervous." I'm like, "Of course you can have a glass of red." She goes, "Really? It's not going to accelerate my breast cancer."

And the idea that people are so anxious about any alcohol intake now is really upsetting to me. And so I do think though that the flip side to that is we have a lot of patients who take on extremely drastic lifestyle changes when they are diagnosed with breast cancer. I always say vegetarian triathletes can get breast cancer too. It's not your fault, and no matter how healthy your lifestyle is, you can get breast cancer. But if someone is of that mindset where they're saying, "I am going to become a vegetarian. I'm going to stop eating this. I'm not going to do that." Alcohol is one of those things that you can eliminate that definitely is proactive about risk reduction.

The last thing that I want to talk about related to risk is super controversial now, but it's a really, I think, important topic, and that's hormones. I am a very, very big believer in hormone replacement therapy, again, as a tool for women to deal with menopausal symptoms. Women struggle every day with things like childcare and work and managing households and so many things, and everything from hot flashes to libido, to mind fog, to brain fog, to all kinds of things, weight loss can be attributed to menopausal symptoms. I do believe that hormones are an extremely important tool for women suffering from menopausal side effects.

I tend to group women into three general buckets as it relates to menopausal symptoms and hormone replacement therapy as an option. Women who are in the general population who really have no predisposing risks to breast cancer, for the most part, they can take hormone replacement safely. There is no situation, however, and this is really important for me to get across, there is no situation where hormone replacement does not increase your risk of breast cancer. It's a small increase, but the idea now that the black box label was repealed on hormone replacement last year misled people to think that there's no risk.

What the black box label did was disproportionately emphasize the risk, which I think was really, really terrible. It led to doctors not being willing to prescribe it and patients feeling that the risks really outweighed the benefit. But really important to know is that in each individual case, we have to assess risk and benefit. There is added risk for breast cancer with hormone replacement therapy. The average woman's risk of getting breast cancer in a lifetime is about 10%. If she goes on hormone replacement, it probably ups her to about 12%. So it's not a huge bump up.

Now, you'll read in the press that hormone replacement therapy increases your risk of breast cancer by 20%. And here's where it gets really tricky. They're not wrong. Why are they not wrong? Because, and this is like a light bulb moment, and this applies to everything you read. The average woman's risk is 10%. What is 20% of 10%? It's two. That's why your risk goes from 10 to 12. So it doesn't go from 10 to 30. It goes from 10 to 12. And I can't tell you how many countless women did not or were unwilling to go on hormone replacement therapy because their perceived increased risk was so dramatic and no one ever sat down to explain to them that that's what that means. So that's the first group.

The second group are women who already are at increased risk for breast cancer for a variety of different things. Maybe they had a biopsy before that showed atypical cells. Maybe they have a family history. And I do believe women at increased risk for breast cancer can be on hormone replacement therapy, again, as long as they're willing to understand and depreciate the added risk. Might it be throwing fuel on the fire if you've had prior biopsies that show atypical cells and increase your risk of breast cancer? Sure. But if you're really struggling, I also say just because you go on hormone replacement therapy for a couple of years, that doesn't mean... you might need it to get you over the

hump. It doesn't mean you need to be on it forever. And for sure, the added risk is incremental with the number of added years. So I don't think it should be an all or nothing type of thing.

The last group, women with breast cancer, are really pretty much still a no-fly zone as it relates to breast cancer. I will tell you there are groups now that are trying to bend those kind of narrow guardrails and say, "Well, if I had triple negative breast cancer or cancer that wasn't fed by hormones, why can't I be on hormones? If I had only DCIS 10 years ago and I had a bilateral mastectomy and I have no breast tissue left, why can't I be on hormones?" And I do think there's a lot of points to be made here. And I do talk to people on an individual basis about these situations. But by and large, the party line is still if you've been diagnosed with breast cancer, that is the one group that really probably shouldn't be on it.

Okay, moving on to screening for a few minutes. There are generally, as I said, three tests, and I think there is so much noise out there and misinformation about these three tests and how they should be utilized. Let's start with mammograms. Mammograms, number one, I was going to save this for the last section on myths, so I'll hold off on that part. Mammograms are the best tool that we have today for picking up breast cancer in women overall. It is the best screening tool. It's tried and true. There have been multiple randomized trials that show that mammograms reduce the risk of dying from breast cancer by early detection in a range of anywhere from 15 to 30%.

The other benefit of mammograms also, which is less commonly discussed, is a study that my group and I put out a few years ago, which I would invite you to take a look at. I noticed, I saw a woman in my office today. She's very affluent, very educated, has not had a mammogram since 2016. She has stage two or stage three breast cancer. She 100% needs a mastectomy, whereas 70 to 80% of women now can have a lumpectomy. She's probably going to need all her lymph nodes removed, probably going to need chemotherapy and multiple other downstream treatments to cure her more advanced disease.

But the point that I'm making from our study is what we looked at at our main campus. I took every woman that walked through our door at Mount Sinai and I grouped them into three buckets. Women who had never had a mammogram diagnosed with breast cancer, women who had had a mammogram, but it was more than two years, hence, and women who had had a mammogram within two years. If you took the first group, sorry, the last group, the women who had had been regular screened and compared them to the other two groups, the women in the first group who had done regular screening, again, were way more likely to be able to have a lumpectomy if they wanted it, way less likely to have nodes involved, spread to the nodes, way less likely to need chemotherapy.

So what I say is not only do mammograms save lives, but they save lives allowing us to do less. If you could cure a breast cancer with chemotherapy or cure it without it, which would you choose? So avoidance of chemotherapy is one of the things our patients talk about all the time. You have a way higher chance of being able to avoid chemotherapy with earlier detection.

The general rules for mammograms are starting at age 40 for the general population and yearly. The endpoint is always a really fun source of debate. Most of the screening trials ended at age 70, 75. I always say that's young for women now. It's certainly younger and younger for me as I get older. So I always say, if you are playing tennis and pickleball and running around after your grandchildren, you can have a mammogram. So I typically advise if what we say, the kind of cut and dried definition is if your life expectancy is less than five years, don't bother, but if it's more than five years, absolutely do it. And keeping in mind that the life expectancy of the average woman now is close to 85, I think that's really good news.

Okay. We also recommend doing mammograms 10 years younger than when your family member was diagnosed if you have a family history. So if my mom had breast cancer at 48, I might start at 38. So that's another little rule of thumb. Adding on ultrasounds. Ultrasounds are being done now in almost

every woman with dense breasts because mammograms can... We already talked about mammograms are the best tests, but they're not perfect. They pick up about 90, 80 to 90% of cancers, but that still leaves a huge gap.

We think they're less effective. We know they're less effective in women with dense breasts. So we typically add on ultrasounds, particularly in women who don't have any other risk factors other than dense breasts. So nowadays women have to be informed of their breast density, and that allows them to empower themselves to ask a doctor and say, "Hey, shouldn't I also be getting an ultrasound? Isn't there a chance my mammogram might miss something?"

MRIs are the test we resort to for women mostly at increased risk. Increased risk can include being a mutation carrier, BRCA or other genes, or having an elevated risk above 20% based on other criteria, and there are ways to calculate risk, online risk tools and things like that.

And so what I would say is that these screening guidelines are very individualized. Women ask me all the time, how do I know if I need to add on an ultrasound? How do I know if I need an MRI? What I say to you is go to the book. There's a whole section on screening and every single chapter, mammogram, ultrasound, MRI, there gives checklists for you to see if any of these criteria ring true for you. And to me, that's a really good way to get guidance in addition to your doctor.

Again, I say if one person reads the book and says, "Gosh, it sounds like I am at higher risk for breast cancer, even though I'm not BRCA positive, maybe I should get an MRI," and approaches their doctor and they're diagnosed with cancer earlier, it will have been worth it. Saving one life, as we know, is like you save the world, right? So I think we're all familiar with that phrase.

The one thing I want to leave you all hanging with, and we can talk about it in the Q&A, is full body scanning. I guess raise your hand on chat if you've done a full body scan, if you've fallen victim to the intense pressure that is the Kardashians and other celebrities for getting full body scans, Prenuvo, MRI, et cetera. All right, we won't put people on the spot. Full body scans are a very, very new, interesting area, and there are risks and there are benefits. Everyone feels that more information is always better, not so fast. There's a chapter in the book on full body scans and the newest cutting edge technology. And one of the things I'll tell you guys is the reason why I am so proud of this book, it's called obviously The Breast Advice, but here's the thing that I'm most proud of, it's not just my advice.

The Breast Advice, every single chapter, whether it's about mammograms, ultrasounds, treatment, being diagnosed under the age of 40, genetics is prefaced by a patient's story and them giving their advice. Some of it a bit controversial. There's a lot of celebrities in the book who I've taken care of who graciously shared their stories, Jill Martin, Chris Everett, Mary Jo Fernandez, a variety of different people. And then there are regular people too, and people who told their story anonymously because I thought their story was too important to tell and really, really important messaging, but they didn't want to glean any attention.

Let's go back to full body scan. In the chapter on full body scanning, there is one person who says, "I think a full body scan saved my life." And there's another who says, "I think a full body scan ruined my life." So I invite you to take a look at that, and I think it's a really good point/counterpoint on the risks and benefits of full body scanning.

Okay. Last area I want to talk about before I guess we open it up has to do with myths. We started out by saying that there are so many myths related to breast cancer and part of the goal, I always said you can't complain about all the misinformation out there without trying to be part of the solution. And tonight is about that, Sharsheret is about that, trying to educate people on genetic testing and why it's so important and screening and all of those things. And the book ended up being about that, which is

trying to educate people and inform. And the book is really my love letter to combating misinformation, my contribution to that all rolled up into one.

So let's start with some of the big ones. This is the one that I use in no matter what speech I give. And I can honestly tell you it never ceases to amaze me no matter how many times you say it, there's always someone, I know everybody's on mute, that audibly gasps. We all know that Sharsheret deals with a lot of women who are known to be at increased risk for breast cancer and largely related to genetic predisposition family history. But what if I told you that 90% of women, 90% who get breast cancer have no family history?

Now, why is that important? It's important because the people that I see who come in diagnosed who haven't been screened in 10 years often say to me, "I wasn't getting screened because I didn't think I was at risk. I have no family history. Why would I get screened for a disease I'm not at risk for?" We're all at risk and having no family history does not mean you're not at risk, quite the contrary. So everyone needs to get screened. So that's myth one.

Myth two is that mammograms cause breast cancer. As I said, I was going to circle back to that. It is true mammograms are done with radiation, and the medical conspiracy theorists say that mammograms are just another way that doctors are trying to make people sick so that then they have a disease to treat. It's so outrageous and so enraging, it's hard to listen to. But it is out there and the only way you can combat, again, misinformation is with information. Currently, the dose of radiation you get with a mammogram is the equivalent of four or five long plane flights, transatlantic plane flights.

So what I tell people is really, you're afraid of the radiation from a mammogram, then you really should stop traveling. And you definitely shouldn't live in places like Denver, Mile High City, where there is more radiation in cities at altitude. Because the exposure, the lifelong radiation exposure that someone gets living in a place like Denver compared to New York at sea level is totally different.

So the perception that mammograms, you fight fire with fire, fight fire with facts, fight misinformation with facts. And the dosing of mammography related to radiation is definitely quite minimal. And again, we need to know that there's so much that we do in our lives that involves regular radiation exposure. So that's super important.

And then the last myth before I'll stop with my part is related to biopsy spreading breast cancer. Needle biopsies can be painful. They involve taking a tiny little needle and inserting it in the breast after giving local anesthesia and taking little snippets of tissue out. It is the standard of care and it's how we diagnose breast cancer in the majority of cases. Many, many women come to me dying to get in quickly because they're like, "Oh my God, I had this biopsy. Now it's going to spread the cancer." That's just absolutely not the case. You cannot spread breast cancer by poking it or pushing the cells around. That's not how it works.

So those are kind of the things, again, that I wanted to cover. Again, we talked, I think the cool part is we talked a lot about... One of the things I wanted to point out is if you look at the cover in the title of the book, *The Breast Advice: All You Need to Know About Breast Health Screening and Treatment*, notice there's one keyword missing from this cover and this title, cancer. This book is half about, the whole first half is for regular women who have not been diagnosed with breast cancer. So the first book I wrote 10 years ago, *How to Navigate Your Diagnosis and Treatment* was basically, okay, you have breast cancer, go.

This book is like the prequel in part. The whole first half of the book is about all the things we talked about, screening. I want every 25-year-old to read this book and figure out if they need genetic testing. There are two chapters on genetics. I want every woman to read the book to figure out what is her

individualized appropriate screening regimen. There's a whole chapter there on supplements and food additives and things like that and what to think about.

And then the whole second half of the book is about the different steps of breast cancer treatment, lumpectomy versus mastectomy, mastectomy versus bilateral mastectomy. Again, there's a whole chapter with one woman on one who decided to just do one and one who decided to do both. And how they made those decisions and how those can help other women, their advice, if you will.

But that's really kind of the long and the short of it. I really want to get the information out there. Again, I'd like to get it out to every Jewish woman who's out there. I feel like this is really a point in time for all kinds of reasons that we all know that we have to take care of each other and we have to protect each other and giving each other information and the level of information and support that an institution like Sharsheret does, it's incalculable, the reach and the importance of their mission and what they're doing. I hope my book can play a small part in that in furthering that mission.

Melissa Rosen:

Wow. Oh, am I muted? No, I'm not. Wow. So much information. And I'm happy to say that you answered a lot of our questions. One of the questions was how is this book different than your previous one? So you answered it, it's the prequel, so that's good to know.

Dr. Elisa Port:

Well, I would say it's a prequel and then it's an update. So the first whole half is the prequel, and then the update is really like, you know what the good news is? The great news is that so much has changed. It needed an update. That's all progress.

Melissa Rosen:

Right, right. That's amazing. And that was the second question. Why was it this particular time that you chose to write? And so thank you for that. Your book addresses lifestyle factors and prevention. And you talked about this a little bit, but I'd love for you to expand a tiny bit. What are the risk reduction strategies with the strongest evidence, the ones you encourage most? You talked about weight, you shared about alcohol, but we hear other things out there too. You myth busted about soy, but also along those lines, like lifestyle recommendations, which ones are overemphasized? Which ones are underemphasized? Things like that.

Dr. Elisa Port:

I mean, I really think that, again, let's go back to sugar. It's a huge misconception that sugar feeds breast cancer. No, it does not. And you could cut sugar completely out of your diet. Sugar does feed breast cancer, but it feeds all cells, and it is a basic fuel for every cell in your body. If you do not eat a single gram of processed sugar, your body will take whatever it is you're eating, broccoli, blueberries, anything, and convert it to sugar that your cells need to function. So there's no really doing an end run from a dietary standpoint around this.

I would say it all funnels into weight, so that maintaining a healthy body weight, of course, it's very rare. I write in the book, it's very interesting that most women, we think exercise, there's a whole chapter in exercise. Exercise is really important and probably does have an independent effect, probably reduces hormone circulating. We think green exercise. I'm a big fan of exercising outdoors. I love to run, I love to surf, I love to do a lot of things. The air is cleaner near the ocean, that kind of thing and outside. I think

it's really important to unplug mentally a lot of the mental benefits of exercise you just don't achieve on a treadmill, of course.

So I think all of these things are important and we do a deep dive, but I do think, as I talk about in the book, I've met two women in my entire practice who are skinny, thin, healthy body weight, but don't exercise. Readily admit to never exercising.

Melissa Rosen:

I can relate.

Dr. Elisa Port:

So I think the exercise... Well, that's interesting. Good for you. But not really because it's really important independently. So I think it all really focuses in on weight, and that's why I just know so many women work out so hard and work so hard and they just feel like they can't lose the weight. And I do think it's really an uphill battle and a challenge, especially after a breast cancer diagnosis. So I would focus less on the dietary components. I would also caution people not to get sucked into the bright, shiny objects, the peptides and all of these supplements and things like that.

I'm a very big... I always say to people, if you are at all a person who's skeptical about what you put in your body, if you're that person reading the package insert on a medication or a Tylenol or people come into me and say, "Yeah, I wouldn't even take a Tylenol," the last thing I would put into my body is supplements, and that includes things like vitamins because those things are unregulated and you just don't even know what you're getting. A lot of them are placebo. A lot of them have contaminants. Mostly a lot of them are not manufactured in this country. They're just repackaged here with really cute labels of farm animals and things like that to make you think that they're organic and safe. And so I would say just think twice.

Melissa Rosen:

All right. As long as we're talking about weight, there were a couple of questions that came in about GLP-1s. So one is, other than weight loss and how that relates to cancer risk, is there any evidence that being on a GLP-1 type drug reduces risk of cancer or cancer recurrence?

Dr. Elisa Port:

It's a great question, and the newest evidence is suggesting that. In part because, okay, a couple things. The hard part to figure out is whether, like you said, it's independent of the weight loss, because let's just talk about the reasons why weight loss might reduce the risk of recurrence. The main reason is post-menopausally, we go through menopause and our ovaries shut down and we don't make hormones, but we're still women. I don't grow a beard and my voice doesn't deepen. So where are those hormones coming from? I still have estrogen circulating in my body. They can come from variety of different places. It can come from the adrenals, it can come from the skin, but it can also come from fat stores.

So if you are a person with a fair amount of fat stores, you're going to be producing more estrogen and releasing it into the bloodstream, which then can increase your risk of breast cancer recurrence because you're exposed to that. I think the most important thing for people to realize is that we think of fat stores as these passive globs of tissue that just sit on parts of our body, and we all have it. They're not. Fat stores are super metabolically active and they secrete, for example, not only hormones, but pro-inflammatory agents. We've all heard about inflammation, and maybe that's a trigger for different cancers and cardiac disease.

So there can be a variety of different ways that these GLPs are affecting either directly or indirectly the reduction in breast cancer risk and recurrence.

Melissa Rosen:

And if you're interested in more, one of our upcoming summit webinars is a deep dive on that topic, but I didn't want to ignore the question here tonight because several people asked. Among other questions that more than one person asked, what are the screening opportunities, obligations we should have for recurrence for somebody who has had a mastectomy?

Dr. Elisa Port:

You mean, so how do we screen women who've had a mastectomy?

Melissa Rosen:

For recurrence of breast cancer.

Dr. Elisa Port:

Okay, so I think this gets into a little bit of a dark area, but let's talk about it a little bit. In general, breast cancer can recur in different ways. If you've had a lumpectomy, of course it can recur in that breast. Thankfully, that risk is really low. It's like three or 4%. If you've had a mastectomy, it can recur in the skin or in the muscle, and thankfully that risk is also very low, like 1%. No matter which operation you do, a lumpectomy, a mastectomy, bilateral mastectomy, breast cancer can also occur in a much more ominous way, which is in the body.

That is the thing that's most risky and most dangerous, and that is really the purview of an oncologist in terms of how to screen for that. In general, we don't. We wait for people to describe symptoms, and that's because there's really no early detection. There's no such thing as early detection of stage four disease.

Let's go back to the question. If someone's had a lumpectomy, we know they need mammograms, they need ultrasounds, some need an MRI. In a mastectomy, everything... First of all, if a mastectomy is done properly, there should be less than 1% of all the breast tissue left behind, and all of that microscopic tissue is directly underneath the skin, which a surgeon can feel on exam. And so I don't, nor do most surgeons, who feel that they've done a thorough job screen. There's no deeper tissue, there's nothing behind the implant, there's nothing that you're missing.

I will tell you, I have seen the work of some others who do screen their patients. And look, in general, most surgeons don't see the work of other surgeons unless God forbid that person has had a problem. They do have a recurrence after a mastectomy, and you come to see me and I look, and that can be a light bulb moment where I turn around and say, "This is not how I do a mastectomy. There's so much tissue left behind. This was a setup for recurrence."

And so I would say to a person, if their surgeon is telling them that they should be screened after the mastectomy that he or she performed, that is a red flag that they are worried that they left more breast tissue behind than probably is optimal.

Melissa Rosen:

Okay. That's something very important to keep in mind. We have a lot more questions that have come in and not a lot of time, so I'm going to do a lightning round.

Dr. Elisa Port:

Okay. I'll try to keep my answers short, honey.

Melissa Rosen:

Yeah, yeah. I know I want to keep listening to you, but I want to not ignore questions. You said people who have had breast cancer in general, hormones are a no-go. Does that also include topical, like vaginal estrogen?

Dr. Elisa Port:

No. Great question. No, we feel that there are topical vaginal estrogens that do not get a lot of systemic absorption. I'm so glad someone asked that. It's an incredibly important tool, and we feel that it's very safe.

Melissa Rosen:

Amazing. Two people asked, "What, if any, is the relationship between Lynch syndrome and breast cancer risk?"

Dr. Elisa Port:

Lynch is mostly about colon and uterine, not so much breast. Have I had patients with Lynch syndrome get breast cancer? Yes, absolutely, but it's not your main thing.

Melissa Rosen:

Okay. Let's talk about tamoxifen and aromatase inhibitors. Somebody's having a bad reaction, they should try a different one if possible, but what is the risk for lowering the amount of years one stays on that or opting out of that type of post-major treatment, continued treatment?

Dr. Elisa Port:

Yeah, I mean, I think that we see this all the time and it's so challenging. I think I could never be a medical oncologist because 50% of what they do is try to manage symptoms related to, as you mentioned, endocrine therapy. It's really challenging. We're balancing quality of life and all of the side effects with the absolute fact that these medications at their proper dosing reduce the risk of breast cancer recurrence and metastasis by sometimes more than 50%. So you can't argue with that. Do some women go off of it? Sure, they do. They have to accept the fact that now their risk of recurrence is higher.

And I do have many patients say, "My quality of life is so bad, it's just not worth it." But that's a really individualized choice, and I hope most women, and believe me, I have many friends who I've treated who are, again, athletes, very, very high performers, CEOs, running companies, who are like, "I can't live my life." And so I'm super sympathetic to the complaints and so forth, but I also don't want to miss an opportunity to cure breast cancer.

And what I say to my patients before, if and when they decide to go off is, "If this comes back, you can't would've, should've, could've. We'll never know if it could have been prevented." And that's tough. I always really try to make sure that my patients have exhausted all options. To your point, switching medications, lowering the dose, going back up little by little, titrating it in. I have a really creative oncologist that I work with who says, "Why don't you do every other day and see if you can get people to find a middle path."

That said, people do have to accept the fact that you can't go on less a dose or go off without risking some increased recurrence rates. We know this is where the medicine works. When you stop having side effects, it may be that the medicine isn't working as well, and that's just an unfortunate trade-off.

Melissa Rosen:

Okay. I wish we could spend another hour getting you to answer questions. The last question I have is actually not for you, but for those who have joined us tonight, I know we're all interested in learning more. And so Dr. Port's book is a fantastic resource. We are putting the link to purchase the book in the chat now. When I went to grab the link off of Amazon as I was finalizing the script, it is on early Prime Day deals. So for-

Dr. Elisa Port:

So buy lots of them. Buy a bunch.

Melissa Rosen:

... two thirds off, right? You are not going to get a better deal for less than \$10, you can get life-saving information, so that's an option. Okay. As we wrap up, Dr. Port, I just want to thank you for your insights, your passion. Congratulations on this book, and thank you for being with us today.

Dr. Elisa Port:

It is my total honor. Again, Sharsheret is near and dear to my heart. I love what you guys are doing. I will help and be involved in any way I can.

Melissa Rosen:

And we're going to hold you to that.

Dr. Elisa Port:

You got it.

Melissa Rosen:

Okay. Thank you again to our summit sponsors, the Cooperative Agreement 240061 from the CDC, AstraZeneca, Eisai, GSK, Lilly, Pfizer, Smart State, and Weill Cornell Medicine. I also want to thank our Summit partners once again.

There is an evaluation link in the chat box right now. It takes less than five minutes, and you can still listen to me finish up while doing it. Quick note about some of our upcoming webinars. As part of this year's summit we have some truly amazing national webinars scheduled as well as hundreds of local programs across the country. On October 8th, we have a program on AI and cancer screening. And on October 19th, we've scheduled that one I mentioned, GLP-1s and cancer.

There are so many other amazing national webinars on really innovative topics, menopause and cancer, things like that. So this is just the tip of the iceberg. Please check it out. The summit actually has its own website. I know the link to it was just put in the chat box.

And then finally, please remember that Sharsheret is here for you and your loved ones. We provide emotional support, mental health counseling, other programs designed to help people navigate through a cancer experience. Including before, during the diagnosis, during treatment, short-term survivorship,

long-term survivorship. Should a diagnosis be stage four, all of it, and not just... Anyone impacted. So children, partners, best friends, all of it is completely free, completely confidential. Our contact information is in the chat box.

Once more, we'll put that survey link in, and I want to thank you all for joining us for this really important webinar. You'll get an email next week with a link to the recording and some other resources. Have a wonderful evening. Goodnight.